Disclosure of Ownership and Control Interest Statement

Department of Health and Human Services — Form Approved
Health Care Financing Administration — OMB No.0938-0086

I. Identifying Information

(a) Name of Entity: _____ D/B/A
Provider No.: _____
Vendor No.: _____
Street Address Line One: _____
Street Address Line Two: _____
City/County: _____
State: _____
Zip Code: _____
Telephone No.: _____ Ext. _____
(b) (To be completed by HCFA Regional Office)
Chain Affiliate No.: _____ LB1

II. Answer the following questions by checking "Yes" or "No."

If any of the questions are answered "Yes," list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5% or more in the institution, organization, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, XX?
[ ] Yes [ ] No LB2

B. Are there any directors, officers, agents, or managing employees of the institution, agency, or organization who have been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?
[ ] Yes [ ] No LB3

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)
[ ] Yes [ ] No LB4

III. (a) List names, addresses for individuals, or the EIN organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks. LB5

Name	Address	EIN
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____

(b) Type of Entity:
[ ] Sole Proprietorship [ ] Partnership [ ] Corporation LB6
[ ] Unincorporated Association [ ] Other (Specify) _____

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions.
(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals, and provider numbers.
[ ] Yes [ ] No LB7

Name	Address	Provider Number
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____

IV.

a) Has there been a change in ownership or control within the year?
[ ] Yes [ ] No
If yes, give date_____ (yyyy) LB8
b) Do you anticipate any change of of ownership or control within the year?
[ ] Yes [ ] No
If yes, when?_____ (yyyy) LB9
c) Do you anticipate filing for bankruptcy within the year?
[ ] Yes [ ] No
If yes, when?_____ (yyyy) LB10

V. Is this facility operated by a management company or leased in whole or part by another organization?
[ ] Yes [ ] No
If yes, give date of change in operations: _____ (yyyy) LB11

VI. Has there been a change in Administrator, Director, or Nursing or Medical Director within the last Year?

[ ] Yes [ ] No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address or Corporation and EIN.)

[ ] Yes [ ] No

Name:_____

EIN #: _____ LB13

Address: _____ LB14

(b) If the answer to Question VII a. is no, was the facility ever affiliated with a chain? If yes, list Name, Address of Corporation, and EIN.)

[ ] Yes [ ] No LB18

Name:_____

EIN #: _____

Address: _____ LB19

VIII. Have you increased your bed capacity by 10% or more than 10 beds, whichever is greater, within the last two years?

[ ] Yes [ ] No LB15

If yes, give year of change :_____(yyyy)

Current no. beds: _____ LB16

Prior no. beds: _____ LB17

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the state agency or the secretary, as appropriate.

Authorized Representative

Name: _____

Title: _____

Signature: _____

Date: ____/_____/_____ (mm/dd/yy)

Remarks:

_____

Mail this form to:

Health Care Facilities Division
825 North Capitol Street, NE
2nd floor
Washington, DC 20002
(202) 442-5888